U.S. Department of Justice
Civil Division

Radiation Exposure Compensation Program
"Interim" Onsite Participant Claim Form

Interim claim form for cases filed after enactment of the Radiation Exposure Compensation Act Amendments of 2000 where an individual participated onsite in an atmospheric test of a nuclear device and later developed a specified compensable disease. A claimant or persons seeking compensation on behalf of a claimant (if claimant is deceased) may apply.

INSTRUCTIONS:
Complete all Parts of the white "Interim" Onsite Participant Claim Form and all Parts (except Parts 4 and 7) of the attached blue "Onsite Participant" Form.
Contact the Radiation Exposure Compensation Program for additional help at 1-800-729-7327.

Part A This section replaces Part 4 of the blue "Onsite Participant" Form. Part A concerns information about the SPECIFIED COMPENSABLE DISEASE that the claimant developed after onsite participation in an atmospheric test of a nuclear device.

- Place a check next to the SPECIFIED COMPENSABLE DISEASE that the claimant developed.
- If the claimant did NOT become ill with one of the listed diseases, he or she is not eligible for compensation.

_____leukemia, but NOT chronic lymphocytic leukemia
_____multiple myeloma
_____lymphomas, other than Hodgkin's disease
_____primary cancer of the thyroid
_____primary cancer of the female breast
_____primary cancer of the esophagus
_____primary cancer of the liver
_____lung cancer
_____primary cancer of the urinary bladder
_____primary cancer of the colon
_____ primary cancer of the stomach
_____ primary cancer of the pharynx
_____ primary cancer of the small intestine
_____ primary cancer of the pancreas
_____ primary cancer of the male breast
_____ primary cancer of the bile ducts
_____ primary cancer of the gall bladder
_____ primary cancer of the salivary gland
_____ primary cancer of the brain
_____ primary cancer of the ovary

Part B This section replaces Part 7 of the blue "Onsite Participant" Form. Part B concerns PREVIOUS PAYMENTS OF MONEY in connection with the specified compensable disease for which this claim is submitted under the Radiation Exposure Compensation Act Amendments of 2000.

- Answer the two questions below by circling the correct answer to each question.
- If you circled "YES", please use a separate sheet of paper to identify the date, amount, and person or organization from whom EACH AND EVERY payment of money was received, and explain the circumstances surrounding the payment.

Yes No Have you or anyone else received any payment made pursuant to a final award or settlement on a claim (other than a claim for workers' compensation), against any person that is based on the illness for which this claim is submitted?

Yes No Have you or anyone else received any payment made by the Department of Veterans Affairs that is based on the illness for which this claim is submitted? (Include disability payments made to the person who became ill, Dependency and Indemnity Compensation payments made due to the death from illness for which this claim is submitted. Do NOT

include retirement pensions, medical and dental benefits, education benefits, loans and other noncash benefits, vocational rehabilitation benefits, SGLI or VGLI or other life insurance benefits, or burial benefits.)

Part C Signature and Date.

I declare under penalty of perjury that the above information is true, correct, and complete to the best of my knowledge and belief.

_____ Date_____

Signature of Claimant or Person Filing on Behalf of Claimant
or Legal Guardian

Civil Penalty for Presenting Fraudulent Claim or Making False Statements or Using False Record
The claimant shall forfeit and pay to the United States the sum of $10,000 plus treble the amount of damages sustained by the United States. (See 31 U.S.C. § 3729).

Criminal Penalty for Presenting Fraudulent Claim or Making False Statements
Fine and imprisonment for not more than 5 years. (See 18 U.S.C. §§ 287, 1001).

You may file a claim by completing the white "Interim" Onsite Participant Claim Form and the attached blue "Onsite Participant" Form (except Parts 4 and 7) and mailing them to:

Radiation Exposure Compensation Program
U.S. Department of Justice
P.O. Box 146
Ben Franklin Station
Washington, D.C. 20044-0146

OMB Approval No. 1105-0052
Expires 2/95

U.S. Department of Justice
Civil Division

Radiation Exposure Compensation Program
"Onsite Participant" Form

Claim form for cases where a person participated onsite in an atmospheric test of a nuclear device and later developed a specified compensable disease listed in Part 4 of this form.

- Complete each of the 8 Parts of this form.
- Refer to the Blue Guidebook for help.
- Contact the Radiation Exposure Compensation Unit for additional help at 1-800-729-RECP.

Part 1

- This Part concerns information about YOU - THE PERSON FILING THIS CLAIM.
- Fill in the spaces below.
- Attach an original or certified copy of your birth certificate.
- If you are the legal guardian of the person eligible to file this claim, check here ☐ and fill in the spaces below with information about the person on whose behalf you are filing. Fill in the information requested in Part 8 regarding the name and address of the legal guardian.

First name

Middle name

Last name

Other names (e.g., maiden, name change, etc.)

Mailing address

Zip code

Residence address (if different from mailing address)

Phone number (day) ___-___-____

Phone number (evening) ___-___-____

Social security number ___-___-____

Date of Birth (month/day/year)

Place of birth (city, county, state)

- ☐ Check here if you are a member of an Indian Tribe.
- Print the name of your Tribe and your census number here: _____
- If you are a member of an Indian Tribe, you do not need to provide the records requested in this Part or in Parts 2 and 3 of this form at this time. We will contact the Vital Statistics Office of your Tribe and obtain the necessary records for you.

Part 2

- This Part concerns information about the PERSON WHO BECAME ILL WITH A SPECIFIED COMPENSABLE DISEASE.
- ☐ Check here if YOU – THE PERSON FILING THIS CLAIM – are the person who became ill with a specified compensable disease. Go to Part 3.
- If you are not the person who became ill, fill in the spaces below.
- Attach an original or certified copy of the birth and death certificate of the person who became ill.

First name

Middle name

Last name

Other names (e.g., maiden, name change, etc.)

Social security number

Date of Birth (month/day/year)

Date of Death (month/day/year)

Place of birth (city, county, state)

Place of death (city, county, state)

Part 3

- This Part concerns information about your RELATIONSHIP with the person you identified in Part 2 of this form as having a specified compensable disease.
- Select the relationship that YOU – THE PERSON FILING THIS CLAIM – had with the person who became ill with a specified compensable disease (the person identified in Part 2 of this form):

  SELF – go to Subpart (a)
  SPOUSE – go to Subpart (b)
  CHILD – go to Subpart (c)
  PARENT – go to Subpart (d)
  GRANDCHILD – go to Subpart (e)
  GRANDPARENT – go to Subpart (f)

a. ☐ Check here if YOU – THE PERSON FILING THIS CLAIM – are the person identified in Part 2 who became ill with a specified compensable disease. Go to Part 4, now.

b. ☐ SPOUSE. Check here if you are filing this claim as the SPOUSE of the person identified in Part 2 who became ill with a specified compensable disease. Please answer the following questions. Go to Part 4 after you have answered these questions.

Yes ☐ No ☐ Is the person identified in Part 2 deceased? If "NO", you are not eligible to file this claim. Please consult your Guidebook.

Yes ☐ No ☐ Were you married to the person identified in Part 2 for at least one year immediately prior to that person's death? If "NO", you are not eligible to file this claim. Please consult your Guidebook. If "YES", attach an original or certified copy of your marriage certificate.

c. ☐ CHILD. Check here if you are filing as a CHILD of the person identified in Part 2 who became ill with a specified compensable disease. Please answer the following questions. Go to Part 4 after you have answered the questions.

Yes ☐ No ☐ Is the person identified in Part 2 deceased? If "NO", you are not eligible to file this claim. Please consult your Guidebook.

Yes ☐ No ☐ Was the person identified in Part 2 ever married? If "YES", list the name of each spouse, the date and place each marriage began and ended, and the date and place of divorce or death of the last spouse of the person identified in Part 2. Attach an original or certified copy of the marriage certificate and the death certificate or divorce decree for each spouse of the person identified in Part 2.

Use a separate sheet of paper if additional space is needed.

Yes ☐ No ☐ Are you a natural child of the person identified in Part 2?

Yes ☐ No ☐ Are you an adopted child of the person identified in Part 2? If "YES", attach an original or certified copy of the judicial decree of adoption.

Yes ☐ No ☐ Are you a step-child who lived in a regular parent-child relationship with the person identified in Part 2? If "YES", attach original or certified copies of records (e.g., school records) indicating that you lived with the person identified in Part 2 in a regular parent-child relationship.

Yes ☐ No ☐ Were there any other natural, adopted, or step-children of the person identified in Part 2 other than you? If "YES", list the name of each child, the date and place of birth of each child, and the date and place of death or current address of each child. Attach an original or certified copy of the death certificate for each deceased child.

Use a separate sheet of paper if additional space is needed.

d. ☐ PARENT. Check here if you are filing as the PARENT of the person identified in Part 2 who became ill with a specified compensable disease. Please answer the following questions. Go to Part 4 after you have answered these questions.

Yes ☐ No ☐ Is the person identified in Part 2 deceased? If "NO", you are not eligible to file this claim. Please consult your Guidebook.

Yes ☐ No ☐ Was the person identified in Part 2 ever married? If "YES", list the name of each spouse, the date and place each marriage began and ended, and the date and place of divorce or death of the last spouse of the person identified in Part 2. Attach an original or certified copy of the marriage certificate and the death certificate or divorce decree for each spouse of the person identified in Part 2.

Use a separate sheet of paper if additional space is needed.

Yes ☐ No ☐ Did the person identified in Part 2 have any natural, adopted, or step-children? If "YES", list the name of each child, the date and place of birth of each child (or date and place of adoption), and the date and place of death of each child of the person identified in Part 2. Attach an original or certified copy of the certificate of each child.

Use a separate sheet of paper if additional space is needed.

Yes ☐ No ☐ Are you a natural father/mother of the person identified in Part 2?

Yes ☐ No ☐ Are you an adoptive father/mother of the person identified in Part 2? If "YES", attach an original or certified copy of the judicial decree of adoption.

Yes ☐ No ☐ Are there any living natural or adoptive parents of the person identified in Part 2 other than you? If "YES", list the name and address of each parent. If "NO", list the name, and date and place of death of each deceased parent. Attach an original and certified copy of the death certificate of each deceased parent.

e. ☐ GRANDCHILD. Check here if you are filing as a GRANDCHILD of the person who became ill with a specified compensable disease. A member of the Radiation Exposure Compensation Unit will contact you to provide assistance in establishing your relationship with the person who had the specified compensable disease.

f. ☐ GRANDPARENT. Check here if you are filing as a GRANDPARENT of a person who became ill with a specified compensable disease. A member of the Radiation Exposure Compensation Unit will contact you to provide assistance in establishing your relationship with the person who had the specified compensable disease.

Part 4

- This Part concerns information about the SPECIFIED COMPENSABLE DISEASE that the person identified in Part 2 developed after onsite participation in an atmospheric nuclear test.
- Place a check in the box next to the SPECIFIED COMPENSABLE DISEASE that developed after onsite participation in an atmospheric nuclear test.
- If the person identified in Part 2 did NOT become ill with one of the diseases listed on the following page, you are not eligible for compensation. Please consult your Guidebook or contact the Radiation Exposure Compensation Unit.

- ☐ leukemia, but NOT chronic lymphocytic leukemia
- ☐ multiple myeloma
- ☐ lymphomas, other than Hodgkin's disease
- ☐ primary cancer of the thyroid
- ☐ primary cancer of the female breast
- ☐ primary cancer of the esophagus
- ☐ primary cancer of the stomach
- ☐ primary cancer of the pharynx
- ☐ primary cancer of the small intestine
- ☐ primary cancer of the pancreas
- ☐ primary cancer of the bile ducts
- ☐ primary cancer of the gall bladder
- ☐ primary cancer of the liver

Part 5

- This Part concerns RECORDS which can prove that the person identified in Part 2 actually became ill with a specified compensable disease.
- You must either (1) send us one of the records listed on the attachment to this form, or (2) permit us to contact the appropriate state cancer or tumor registry to confirm eligibility for you if the diagnosis of the disease occurred in one of the six states listed below.
- Select the method you wish to use to prove that the person identified in Part 2 actually became ill with a specified compensable disease:
  - ☐ Check here if you are submitting one of the records listed on the Medical Records Attachment.
  - ☐ Check here if you want the Radiation Unit to contact the state cancer or tumor registry indicated below.
- If the person who became ill with a specified compensable disease was diagnosed as having that disease in any of the following states, please place a check in the box next to the appropriate state:

☐ Arizona	☐ New Mexico
☐ Colorado	☐ Utah
☐ Nevada	☐ Wyoming

If you placed a check next to one of these states, then you do not need to provide any documentation to prove the existence of the specified compensable disease at this time. We will contact the appropriate state agency for you if you check here ☐ and fill out and return the Authorization to Release Medical and Other Information page attached to this form.

- Answer the following question if primary cancer of the pancreas is the illness identified in Part 4.

Yes ☐ No ☐ Did the person who became ill with primary cancer of the pancreas consume more than an average of 15 6-ounce portions of regular or decaffeinated coffee per day for twenty (20) years?

Part 6

- This Part concerns information about the ONSITE PARTICIPATION of the person identified in Part 2 who became ill with a specified compensable disease.

For DoD and DoD Contractor Personnel:

Military service number: _____

Name and/or number of military organization or unit assignment and branch of service at the time of the participation onsite:

_____

If civilian, name of agency or company: _____

_____

Name of site where participation occurred: _____

Dates of assignment onsite: _____

Rank and description of official duties, responsibilities, and activities while an onsite participant:

_____

_____

_____

_____

_____

Use a separate sheet of paper if additional space is needed.

For AEC and AEC Contractor Personnel or Public Health Service or Civil Defense Personnel:

Name or other identifying information associated with the individual's organization, unit assignment or employer at the time of the participation onsite: _____

_____

Name of site where participation occurred: _____

Dates of assignment onsite: _____

Description of official duties, responsibilities, and activities while an onsite participant:

_____

_____

_____

_____

_____

Use a separate sheet of paper if additional space is needed.

Part 7

- This Part concerns PREVIOUS PAYMENTS OF MONEY in connection with the specified compensable disease for which this claim is submitted under the Radiation Exposure Compensation Act.
- Answer the questions below by placing a check in the box next to the correct answer to each question.

Yes ☐ No ☐ Have you or anyone else received any payment of money pursuant to final award or settlement on a claim (other than life and health insurance) against any person (including a corporation) that is based on the illness for which this claim is submitted?

Yes ☐ No ☐ Have you or anyone else received any payment of money from the Federal Government that is based on the illness for which this claim is submitted? (Include disability payments made to the person who became ill, Social Security and Dependency and Indemnity Compensation payments made due to death from illness for which this claim is submitted. Do NOT include retirement pensions, medical and dental benefits, education benefits, loans or other noncash benefits, vocational rehabilitation benefits, SGLI or VGLI or other life insurance benefits, or burial benefits.)

If you checked "YES", please use a separate sheet of paper to identify the date, amount, and person or organization from whom EACH AND EVERY payment of money was received, and explain the circumstances surrounding the payment.

Part 8

Have you hired an attorney to represent you for the purpose of filing this claim? Check one:

Yes ☐ No ☐

NOTE: You are not required to hire an attorney to file this claim. If you do wish to be represented by an attorney, you are responsible for making arrangements for that attorney to be paid.

If "YES", please indicate your attorney's name, address, and phone number here:

First name

Middle name

Last name

Firm name

Mailing address

Zip code

Phone number (day)

Phone number (evening)

Your attorney must send a letter to the Radiation Exposure Compensation Unit verifying that he/she is qualified as provided in the regulations and authorized to represent you in this matter.

I swear (or affirm) under penalty of perjury that the information in this claim is true, correct, and complete to the best of my knowledge and belief.

Signature of the person identified in Part 1 or Legal Guardian Date

First name of legal guardian (if applicable)

Middle name

Last name

Mailing address

Zip code

Phone number (day)

Phone number (evening)

Civil Penalty for Presenting Fraudulent Claim or Making False Statements or Using False Record
The claimant shall forfeit and pay to the United States the sum of $10,000 plus treble the amount of damages sustained by the United States. (See 31 U.S.C. 3729).

Criminal Penalty for Presenting Fraudulent Claim or Making False Statements
Fine and imprisonment for not more than 5 years. (See 18 U.S.C. 287, 1001)

You may file this form by mailing it to:

Radiation Exposure Compensation Program
U.S. Department of Justice
P.O. Box 146
Ben Franklin Station
Washington, D.C. 20044-0146

Privacy Act

The authority for the collection of this information is the Radiation Exposure Compensation Act of 1990, 42 U.S.C.A. § 2210 note (West Supp. 1991). The information you provide will be used to verify your identity, to verify your eligibility, and to verify any previous payments made in connection with the compensable disease you identified in Part 4 of the claim form. Some or all of the information you provide may be released to federal, state, and local government agencies or private organizations for the purpose of confirming your identity, your eligibility and any previous payments made in connection with the compensable disease. The information may also be released when otherwise authorized by statute or regulation. Disclosure of the information by you is voluntary; however, it may not be possible to process your claim without the information.

Reporting Burden

Public reporting burden for this collection of information is estimated to average 2.5 hours per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to: Radiation Exposure Compensation Program, U.S. Department of Justice, P.O. Box 146, Ben Franklin Station, Washington, D.C. 20044-0146, and to the Office of Information and Regulatory Affairs, Office of Management and Budget, Washington, D.C. 20503.

U.S. Department of Justice
Civil Division

Authorization to Release Medical and Other Information

To: Arizona Tumor Registry
Colorado Cancer Registry
Wyoming Tumor Registry
New Mexico Tumor Registry
Nevada Statewide Cancer Registry
Utah Cancer Registry

I hereby authorize the release of any and all medical and other information in your possession, custody, and control to a representative of the Radiation Exposure Compensation Unit (RECU), Department of Justice, relating to the individual whose name appears on line 1 of this form. This authorization specifically includes the release of abstracts or summaries created or stored by one of the state agencies listed above as a result of its review of the medical and hospital records, physician notes, and lab reports about this individual. This data is required to determine eligibility for compensation under the Radiation Exposure Compensation Act, 42 U.S.C.A. § 2210.

1. Name of the individual whose records are to be released.

_____

2. Social Security Number of the individual whose records are to be released.

_____

3. Birth date of the individual whose records are to be released.

_____
Month Date Year

3. Name of the individual requesting release of information (if different from the individual listed on line 1).

_____

4. Social Security Number (if different from the individual listed on line 1).

_____

5. Relationship to the individual listed on line 1.

_____

_____ _____
Signature Date

Return this Authorization with the claim form to:

Radiation Exposure Compensation Program
U.S. Department of Justice
P.O. Box 146
Ben Franklin Station
Washington, D.C. 20044-0146

U.S. Department of Justice
Civil Division

Medical Records Attachment

A. This is the Attachment referred to in Part 5 of the claim form. Listed below are the specified compensable diseases and the records which we will accept as proof that the person who became ill actually had the specified compensable disease.

Tear off this Attachment and take it to the doctor or hospital holding the records of the person who became ill with one of the specified compensable diseases listed below.

Show this list to the doctor or hospital and ask them to give you original or certified copies of one or more of the records listed below. Select the record(s) containing a diagnosis of the disease, if possible. Otherwise, send the records listed below that are available. Call the Radiation Unit if you have a question: 1-800-729-RECP.

If the person who became ill had primary cancer of the esophagus, stomach, pharynx, pancreas, or liver, you must also obtain the original or certified copies of the medical records listed in Paragraph B on the last page of this Attachment.

(1) Multiple myeloma:
- a. Pathology report of tissue biopsy
- b. Autopsy report
- c. Report of serum electrophoresis
- d. One of the following summary medical reports
  - i. physician summary report
  - ii. hospital discharge summary report
  - iii. hematology summary or consultation report
  - iv. oncology summary or consultation report
  - v. x-ray report
- e. Death certificate, provided that it is signed by a physician at the time of death.

(2) Lymphomas:
- a. Pathology report of tissue biopsy
- b. Autopsy report
- c. One of the following summary medical reports
  - i. physician summary report
  - ii. hospital discharge summary report
  - iii. hematology summary or consultation report
  - iv. oncology summary or consultation report
- d. Death certificate, provided that it is signed by a physician at the time of death.

(3) Primary Cancer of the Thyroid
- a. Pathology report of tissue biopsy or fine needle aspirate
- b. Autopsy report
- c. One of the following summary medical reports
  - i. physician summary report
  - ii. hospital discharge summary report
  - iii. operative report
  - iv. oncology summary or consultation report
- d. Death certificate, provided that it is signed by a physician at the time of death.

(4) Primary Cancer of the Female Breast:
- a. Pathology report of tissue biopsy or surgical resection
- b. Autopsy report
- c. One of the following summary medical reports
  - i. physician summary report
  - ii. hospital discharge summary report
  - iii. operative report
  - iv. oncology summary or consultation report
  - v. radiotherapy summary or consultation report
- d. Report of mammogram
- e. Report of bone scan
- f. Death certificate, provided that it is signed by a physician at the time of death.

(5) Primary Cancer of the Esophagus:
- a. Pathology report of tissue biopsy or surgical resection
- b. Autopsy report
- c. Endoscopy report
- d. One of the following summary medical reports
  - i. physician summary report
  - ii. hospital discharge summary report
  - iii. operative report
  - iv. radiotherapy report
  - v. oncology summary or consultation report
- e. One of the following radiological studies:
  - i. esophagram
  - ii. barium swallow
  - iii. upper gastrointestinal (GI) series
  - iv. computerized tomography (CT) scan
  - v. magnetic resonance imaging (MRI)
- f. Death certificate, provided that it is signed by a physician at the time of death.

(6) Primary Cancer of the Stomach:
- a. Pathology report of tissue biopsy or surgical resection
- b. Autopsy report
- c. Endoscopy or gastroscopy report
- d. One of the following summary medical reports
  - i. physician summary report
  - ii. hospital discharge summary report
  - iii. operative report
  - iv. radiotherapy report
  - v. oncology summary report
- e. One of the following radiological studies:
  - i. barium swallow
  - ii. upper gastrointestinal (GI) series
  - iii. computerized tomography (CT) scan
  - iv. magnetic resonance imaging (MRI)

f. Death certificate, provided that it is signed by a physician at the time of death.

(7) Primary Cancer of the Pharynx:
- a. Pathology report of tissue biopsy or surgical resection
- b. Autopsy report
- c. Endoscopy report
- d. One of the following summary medical reports:
  - i. physician summary report
  - ii. hospital discharge summary report
  - iii. report of otolaryngology examination
  - iv. radiotherapy summary report
  - v. oncology summary report
  - vi. operative report
- e. Report of one of the following radiological studies:
  - i. laryngograms
  - ii. tomograms soft tissue lateral radiographs
  - iii. computerized tomography (CT) scan
  - iv. magnetic resonance imaging (MRI)
- f. Death certificate, provided that it is signed by a physician at the time of death.

(8) Primary Cancer of the Small Intestine:
- a. Pathology report of tissue biopsy
- b. Autopsy report
- c. Endoscopy report, provided the examination covered the duodenum and parts of the jejunum
- d. Colonoscopy report, provided the examination covered the distal ileum
- e. One of the following medical reports:
  - i. physician summary report
  - ii. hospital discharge summary report
  - iii. report of gastroenterology examination
  - iv. operative report
  - v. radiotherapy summary report
  - vi. oncology summary or consultation report
- f. Report of one of the following radiologic studies:
  - i. upper gastrointestinal (GI) series with small bowel follow through
  - ii. angiography
  - iii. computerized tomography (CT) scan
  - iv. magnetic resonance imaging (MRI)
- g. Death certificate, provided that it is signed by a physician at the time of death.

(9) Primary Cancer of the Pancreas:
- a. Pathology report of tissue biopsy or fine needle aspirate
- b. Autopsy report
- c. One of the following medical reports:
  - i. physician summary report
  - ii. hospital discharge summary report

iii. radiotherapy summary report
iv. oncology summary report

d. Report of one of the following radiographic studies:
i. endoscopic retrograde cholangiopancreatography (ERCP)
ii. upper gastrointestinal (GI) series
iii. arteriography of the pancreas
iv. ultrasonography
v. computerized tomography (CT) scan
vi. magnetic resonance imaging (MRI)

e. Death certificate, provided that it is signed by a physician at the time of death.

(10) Primary Cancer of the Bile Duct:

a. Pathology of tissue biopsy or surgical resection
b. Autopsy report
c. One of the following summary medical reports
i. physician summary report
ii. hospital discharge summary report
iii. operative report
iv. gastroenterology consultation report
v. oncology summary or consultation report

d. Report of one of the following radiographic studies:
i. ultrasonography
ii. endoscopic retrograde cholangiography
iii. percutaneous cholangiography
iv. computerized tomography (CT) scan

e. Death certificate, provided that it is signed by a physician at the time of death.

(11) Primary Cancer of the Gall Bladder:

a. Pathology report of tissue from surgical resection
b. Autopsy report
c. One of the following radiological studies
i. computerized tomography (CT) scan
ii. magnetic resonance imaging (MRI)
iii. ultrasonography

d. One of the following summary medical reports
i. physician summary report
ii. hospital discharge summary report
iii. operative report
iv. radiotherapy report
v. oncology summary or consultation report

e. Death certificate, provided that it is signed by a physician at the time of death.

(12) Primary Cancer of the Liver:

a. Pathology report of tissue biopsy or surgical resection
b. Autopsy report
c. One of the following summary medical reports
i. physician summary report
ii. hospital discharge summary report
iii. oncology summary report

iv. operative report
v. gastroenterology report

d. One of the following radiological studies
i. computerized tomography (CT) scan
ii. magnetic resonance imaging (MRI)

e. Death certificate, provided that it is signed by a physician at the time of death.

(13) **Leukemia (other than chronic lymphocytic leukemia):**

a. Bone marrow biopsy or aspirate report
b. Peripheral white blood cell differential count report
c. Autopsy report
d. Hospital discharge summary
e. Physician summary
f. Death certificate, provided that it is signed by a physician at the time of death.

B. If the person who became ill had primary cancer of the esophagus, stomach, pharynx, pancreas, or liver, you must also submit original or certified copies of all medical records listed below that were created 6 months before, or 6 months after, the date the person who became ill was diagnosed with the specified compensable disease.

(1) all history and physical examination reports
(2) all operative reports
(3) all pathology reports
(4) all physician or hospital discharge summaries.

* U.S. G.P.O.:1992-312-344:60123